UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

EMBEDA (morphine sulfate/naltrexone)

Patient name_____Medicaid I.D. # or SS#_____

Physician Name:_____NPI#_____ Contact person_____

Dr. Phone#_____Dr. Ext. and opt._____Dr. Fax#_____

Pharmacy_____Pharmacy Phone#:_____Pharmacy Fax #_____

Requested Medication:_____Strength_____Frequency/Day_____

All information to be legible, complete and correct or form will be returned

_____

FAX DOCUMENTATION FROM <u>PROGRESS NOTES</u> AND THIS COMPLETED FORM TO (801) 536-0477

INITIAL CRITERIA:

- Documented diagnosis of drug abuse, and
- Documented history of chronic pain, and
- No concomitant use of alcohol
- Pain management contract

AUTHORIZATION:

Initial 1 year.

RE-AUTHORIZATION:

- An updated letter of medical necessity.
- Pharmacy may call for an NDC number change at (801) 538-6155, options 3, 3, 2.

(7/12/10)